Collaborative Care Reduced Suicidal Ideation in the Elderly

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SAN DIEGO — Older adults with depression who received collaborative care from a primary care physician and a care manager had significantly less suicidal ideation, compared with their counterparts who received usual care, results from a 2-year study showed.

The finding supports the use of collaborative care to reduce the risk of suicide in elderly patients, Jürgen Unützer, M.D., said at the annual meeting of the American Association for Geriatric Psychiatry.

Fewer than 10% of older adults with depression see a mental health professional. And when a primary care physician refers an older adult to a mental health professional, only about half follow through on the referral, said Dr. Unützer, professor and vice-chair of the department of psychiatry and behavioral health sciences at the University of Washington, Seattle.

In a randomized study, Project IMPACT (Improving Mood: Promoting Access to Collaborative Care), Dr. Unützer and his associates enrolled 1,801 older adults with a Structured Clinical Interview for DSM-III-R diagnosis of major depression and/or dysthymia to receive collaborative care for depression or usual care as recommended by their primary physicians. The 2-year study took place at 18 primary care clinics in five states.

Overall, 895 patients received usual care and 906 received collaborative stepped care at their primary care clinics. All patients were observed at baseline and at 3, 6, 12, 18, and 24 months. Patients in the usual care arm were told, "We're going to observe you, but you can do what you would normally do" for your depression, he said.

Patients in the collaborative care arm were encouraged to choose treatment in consultation with their primary care physicians. Care managers—usually a nurse or a psychologist—helped physicians follow and manage these patients by providing patient education, monitoring symptoms via interviews, and administering the Patient Health Questionnaire–9. They also helped with treatment such as behavior activation, support of prescribed antidepressant medication, and brief psychotherapy.

"We also added a consulting psychiatrist who would come to the clinic once a week for 1-2 hours and go over the caseload of all the patients these care managers were following and provide feedback on the care and, if needed, see a patient in consultation," Dr. Unützer added.

Overall, about 17% of patients in the study met criteria for major depression, 32% met criteria for dysthymia, and 53% met criteria for both. "This is a pretty depressed group of older adults," he said.

At 1 year, the percentage of patients in the usual care group who reported thoughts of suicide had risen from 13% to 16%, compared with a decrease from 15% to 10% in the collaborative care group. The rates were similar at 2 years: 14% for usual care and 10% for collaborative care.

In addition, between baseline and 1 year, the number of patients in the usual care group who reported having any bothersome thoughts about death or dying slightly improved from 58% to 51%, while patients in the collaborative care group greatly improved from 56% to 32%.

In surveys conducted 2 years after baseline, there was little change in the rate for patients in the usual care group (50%), but a higher number of patients in the collaborative care group reported having thoughts about death or dying (42%).

Dr. Unützer and his associates intervened 135 times for 108 patients whom they deemed at high risk for suicide. Of these, 89 times were for patients in the usual care group, while 49 times were for patients in the collaborative care group. There were no completed suicides.

Patient characteristics that were significantly associated with the rate of suicidal ideation at 1 and 2 years were advancing age, male gender, number of comorbid medical conditions, baseline anxiety status, baseline depression severity, and baseline overall quality of life. ■

Symptom Scale Proves Superior in Finding Depression, Anxiety in Elderly Patients

SAN DIEGO — A multisymptom scale identified elderly primary care patients with depression and anxiety symptoms who were missed by the standard 15-item Geriatric Depression Scale, results from a large pilot study have found.

The finding suggests that elderly patients may respond better to less-overt questions about depressive symptoms, Angela Hoth, Pharm.D., said in an interview during a poster session at the annual meeting of the American Association for Geriatric Psychiatry.

The 'greatest surprise' was that the symptom scale identified 64 depressed patients who were nondepressed according to the GDS.

"We're finding that a lot of people will deny that they have depressive symptoms as defined by the GDS, or they don't associate those particular symptoms with what they're feeling," said Dr. Hoth, a clinical pharmacy specialist with the Iowa City VA Medical Center.

"If we asked them questions about symptoms, like 'How are you feeling physically over time?' and 'How is that affecting your overall quality of life?' we were able to pick up some patients that the standard GDS didn't pick up. We might be able to avoid missing some people in primary care by asking them more about their symptoms and relating that back to depression, rather than asking them the regular DSM-type of symptom questions," she explained.

The instrument used by the investigators is the Elderly Symptom Assessment Scale (ESAS), a measure developed to identify adverse drug events in VA patients. It contains six depression-related items (sadness, concentration, memory, fatigue, sleep, appetite) and three anxiety-related items (anxiety, irritability, and restlessness). Results are reported as a symptom count, with a range of 0-9. The ESAS contains 47 overall symptoms.

Of the 351 cognitively intact VA outpatients studied by Dr. Hoth and her associates, 94 (27%) screened positive for depression by the GDS and 121 (34%) by the ESAS. The ESAS identified 64 depressed patients classified as nondepressed by the GDS. Dr. Hoth considered this the "greatest surprise" of the study.

In addition, patients who were very somatic had a lot more anxiety as part of their depression, she added. "In a veteran population that is significant, at least for how we're going to approach treating them, because a lot of them don't want to admit they're depressed. There's still a lot of stigma." ■

CBT Effective for Anxiety Disorder In the Elderly

SAN DIEGO — Data increasingly support the use of individualized cognitive-behavioral therapy in primary care as a treatment for late-life generalized anxiety disorder, Melinda A. Stanley, Ph.D., said at the annual meeting of the American Association of Geriatric Psychiatry.

"A CBT approach is time-limited, directive, and collaborative, which makes it more palatable," said Dr. Stanley, a psychologist of the department of psychiatry and behavioral sciences at Baylor College of Medicine, Houston. "We also have a fair amount of efficacy data now for younger adult populations with GAD that cognitive-behavioral therapy can be effective," she said.

In a pilot study published in 2003, Dr. Stanley and her associates enrolled 12 elderly patients with generalized anxiety disorder (GAD) and a Mini-Mental State Examination score of 24 or greater in a randomized trial of individualized CBT treatment vs. "usual care" for late-life GAD.

Compared with controls, patients in the cognitive-behavioral therapy group showed significant improvements in GAD severity, worry, and depression.

Patients were recruited from primary care waiting rooms, physician referral, or self-referral.

The mean age of patients was 71 years; 83% were women and about 50% were Caucasian. Half of the study participants were using psychotropic medications.

The six patients who were in the CBT group received 8-10 sessions of CBT that included components of problem-solving training, sleep management skills, and increased attention to learning and memory difficulties (Am. J. Geriatr. Psychiatry 2003;11:92-6).

"We also are able to administer the intervention with more flexibility, primarily because we're administering it to individuals rather than to groups," Dr. Stanley explained when describing the treatment approach, which continues to be studied.

"We can vary the number and scheduling of the sessions. We can do home visits if necessary, and we can change the emphasis on different treatment components as needed. For example, some patients come to us who don't have much in the way of [sleep] difficulty, so we don't spend much time teaching behavioral sleep skills."

The treatment lasted for an average of 8 weeks.

Patients in the control group received usual care with telephone follow-up. "We called them biweekly to make sure no emergency services were needed and to try and reduce hospital admission," she said.

Compared with controls, patients in the CBT group experienced statistically significant improvements in GAD severity, worry as measured by the Penn State Worry Questionnaire, and depression based on the Beck Depression Inventory.

There were no differences between the two groups in terms of the number of mental health referrals or visits, total number of medical visits, or number of new psychotropic medications.

On the basis of results of the pilot study, Dr. Stanley and her associates have launched a larger trial funded by the National Institute of Mental Health. The goal is to randomly assign 150 older primary care patients with GAD to receive either CBT or usual care with an evaluation of outcome made by an independent investigator.